STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	LDING	00	COMPL	ETED
			A. BUII B. WIN			12/31/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	1			16TH ST		
CDOWNI	POINTE OF INDIAN	IAPOLIS			APOLIS, IN 46219		
CROWN	FOINTE OF INDIAN	NAFOLIS		INDIAN	AFOLIS, IN 402 19		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0000							
	This visit was f	or the Investigation of	R00	000	Neither signing or submission	of	
	Complaint IN00	0120489.			this plan of correction shall		
	•				constitute an admission of any	′	
	Complaint IN00	1120489 -			deficiency or of any fact or		
	•	State deficiencies			conclusion set forth in the	la ta	
					"Statement of Deficiences". T		
		Illegation are cited at			plan of correction is provided a evidence of the facility's desire		
	R241.				comply with the regulations ar		
					continue to provide quality car		
	Survey Dates:	December 28, 31			common to provide quanty can	•	
	2012						
	Facility number	r: 005729					
	Provider numb						
	AIM number: N						
	0						
	Survey team:						
	Chuck Stevens	son RN					
	Census bed type	pe:					
	Residential: 63						
	Total: 63						
	Census payor	tvne:					
	Other: 63	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
	Total: 63						
	Sample: 9						
	This state findi	ng is cited in					
	accordance wit	th 410 IAC 16.2.					
	Ouality review	1/04/13 by Suzanne					
	Williams, RN	170-7 TO by Guzanne					
	vviiiiaiii5, MN						
					l		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State Form Event ID: OWZU11 Facility ID: 005729 If continuation sheet Page 1 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 12/31/2012
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF INDIANAPOLIS			STREET A 7365 E	ADDRESS, CITY, STATE, ZIP CODE 16TH ST APOLIS, IN 46219	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE

State Form Event ID: OWZU11 Facility ID: 005729 If continuation sheet Page 2 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
			B. WIN			12/31/	/2012
			D. (VII)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			16TH ST		
CROWNPOINTE OF INDIANAPOLIS					IAPOLIS, IN 46219		
					02.0, 102.10		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0241	410 IAC 16.2-5-4	. , . ,					
	Health Services -	ation of medications and					
	` '	esidential nursing care shall					
		the resident 's physician					
		ervised by a licensed nurse					
		or on call as follows:					
		all be administered by					
		personnel or qualified					
	medication aides						
	Based on reco		R02	241	On 1-8-2013 CrownPointe of		01/14/2013
		acility failed to ensure			Indianapolis Resident Service		
	residents, who	were dependent on			Director re-assessed Resident	(H	
	insulin injectior	ns for control of			per a new Medication Self Administration Assessment, to	`	
	diabetes mellit	us and were not			include assessment of	,	
	competent to a	dminister their own			accu-checks and insulin		
		eived appropriate			injections. Resident H		
	•	es and had physician's			demonstrated a clear		
	_	d, for 2 residents			understanding of her physician	า	
		and J) of 5 reviewed for			orders for accu-checks and		
	,	•			insulin injections. Additionally 1-8-2013 CrownPointe of	On	
		of insulin in a sample			Indianpolis Resident Services		
	of 9.				Directore re-assessed Reside		
					per a new Medication Self		
	Findings includ	le:			Adminstration Assessment, to		
					include assessment of		
	1. The record	of Resident H was			accu-checks and insulin		
	reviewed on 12	2/31/12 at 10:15 a.m.			injections. Resident J		
					demonstrated a clear understanding of her physician	2	
	Diagnoses incl	uded, but were not			orders for accu-checks and	Ī	
	_	etes mellitus, chronic			insulin injections. All residents	3	
		monary disease,			who have physician orders for		
	· ·	coronary artery			accu-checks and/or insulin		
	disease, and d	•			injections were reassessed		
	i uiscasc, aiiu u	emenua.			between January 8, 2013 -		
	A	a a a mito da ati a mila da a fila da a			January 11, 2013; for		
		ecapitulation of orders			understanding and ability to		
	for December 2				perform accu-checks and/or insulin injections, with or without	n it	
	Resident H wa	s to test her blood			insum injections, with or without	ul	

State Form Event ID: OWZU11 Facility ID: 005729 If continuation sheet Page 3 of 11

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF INDIANAPOLIS INDIANAPOLIS, IN 48219 SUMMARY STATEMENT OF DEPICIENCIES ID ROUNDERS PLAN OF CORRECTION SUMMARY STATEMENT OF DEPICIENCIES ID ROUNDERS PLAN OF CORRECTION ON THE SEARCH APPROVIDER OF INDIANAPOLIS INDIANAPOLIS, IN 48219 ID ROUNDERS PLAN OF CORRECTION ON THE SEARCH APPROVIDER OF THE INDIANAPOLIS IN ROUNDERS PLAN OF CORRECTION ON THE SEARCH APPROVIDER OF THE INDIANAPOLIS OF THE PROPERTY OF THE P	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF INDIANAPOLIS (A) ID SUMMARY STATEMENT OF DETICENCES) TAG: SUMMARY STATEMENT OF DETICENCES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING ENDORMATION) Sugar twice daily, and was to take 10 units of Levemir insulin at 10:00 p.m. each day by injection. A "Notice of Action Supplemental Information for Providers" form from the State Medicaid Agency, dated 9/25/12 and noted to be a Plan of Care for the period of 9/24/12 through 8/31/13, indicated "Cit (client) does require assistance with med prepIt was reported through the cit's dtr (daughter) that the cit has been repeatedly hospitalized in the past for not taking meds (medications) as prescribed" A "Medication Self Administration Assessment" dated 12/12/12, indicated Resident H had diagnoses of dementia and depression, was not independent for self administration after receiving pre-dispensed medication using the Doc-Dose system. The form indicated "Special medication needs: Staff will administer medications as scheduled." Resident H T's record contained no documentation for the administration of intervention for the administration intervention for the administration intervention for the administration intervention for the administration intervention for	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RUII DING	00	COMPLETED
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INJUDENCE OF INDIANAPOLIS INDIANAPOLIS, IN 46219 INDIANAPOLIS			l .		ADDRESS CITY STATE ZIP CODE	
INDIANAPOLIS, IN 46219 INDIAN	NAME OF P	PROVIDER OR SUPPLIER	t			
SUMMARY STATEMENT OF DEFICIENCIES TAG	CROWNI	POINTE OF INDIAN	JAPOLIS			
PREFIX TAG REGULATORY OR LISC IDENTIFYING INFORMATION DATE					32.0, 102.10	1
sugar twice daily, and was to take 10 units of Levemir insulin at 10:00 p.m. each day by injection. A "Notice of Action Supplemental Information for Providers" form from the State Medicaid Agency, dated 9/25/12 and noted to be a Plan of Care for the period of 9/24/12 through 8/31/13, indicated "Cit (client) does require assistance with med prepIt was reported through the clt's dtr (daughter) that the clt has been repeatedly hospitalized in the past for not taking meds (medications) as prescribed" A "Medication Self Administration Assessment" dated 12/12/12, indicated Resident H had diagnoses of dementia and depression, was not independent in medication administration, and was not independent for self administration after receiving pre-dispensed medication needs: Staff will administer medications as scheduled." Resident H's record contained no documentation of any plan or intervention for the Aerecomental supervision. No other residents were identified to be affected A new tracking system has been developed for all residents who have physicians orders for accu-checks and/or insulin injections. The Resident Service Director, Executive Director or designee will review documentation weekly on-going.					PROVIDER'S PLAN OF CORRECTION	` ′
sugar twice daily, and was to take 10 units of Levemir insulin at 10:00 p.m. each day by injection. A "Notice of Action Supplemental Information for Providers" form from the State Medicaid Agency, dated 9/25/12 and noted to be a Plan of Care for the period of 9/24/12 through 8/31/13, indicated "Cit (client) does require assistance with med prepIt was reported through the cit's dtr (daughter) that the cit has been repeatedly hospitalized in the past for not taking meds (medications) as prescribed" A "Medication Self Administration Assessment" dated 12/12/12, indicated Resident H had diagnoses of dementia and depression, was not independent for self administration administration, and was not independent for self administration after receiving pre-dispensed medication using the Doc-Dose system. The form indicated "Special medication needs: Staff will administer medications as scheduled." Resident H's record contained no documentation of any plan or intervention for the administration of		`			CROSS-REFERENCED TO THE APPROPRIA	TE
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administration, and was not independent for self administration after receiving pre-dispensed medication using the Doc-Dose system. The form indicated "Special medication needs: Staff will administer medications as scheduled." Resident H's record contained no documentation of any plan or intervention for the administration of		of dementia an	d depression, was not			
administration, and was not independent for self administration after receiving pre-dispensed medication using the Doc-Dose system. The form indicated "Special medication needs: Staff will administer medications as scheduled." Resident H's record contained no documentation of any plan or intervention for the administration of		independent in	medication			
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Resident H's record contained no documentation of any plan or intervention for the administration of						
Resident H's record contained no documentation of any plan or intervention for the administration of			ilications as			
documentation of any plan or intervention for the administration of		scrieduled."				
documentation of any plan or intervention for the administration of						
intervention for the administration of						
			* *			
Resident H's insulin injections as						
		Resident H's in	sulin injections as			

State Form Event ID: OWZU11 Facility ID: 005729 If continuation sheet Page 4 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		Î ´	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		IPLETED 31/2012
			B. WING			7 1/20 12
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CO)DE	
	POINTE OF INDIAI	NAPOLIS		16TH ST APOLIS, IN 46219		
				AFULIO, IN 40219		
(X4) ID			ID	PROVIDER'S PLAN OF CORR		(X5)
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)		COMPLETION DATE
TAG		*	TAG			DATE
		e "Medication Self Assessment" of				
	12/12/12.	Assessment of				
	12/12/12.					
	During an into	nvious with the Desident				
	_	rview with the Resident stor on 12/31/12 at 3:45				
	p.m., she indic					
		"Medication Self				
	•	Assessment" of				
		esident H personally,				
		urately represented her				
		t that time. She				
		had no documentation				
		plans or interventions to				
		t H's needs related to				
		ections, and the facility				
		administering the				
		wing the assessment.				
	,	9				
	2. The record	of Resident J was				
		2/31/12 at 11:30 a.m.				
	Diagnoses inc	luded, but were not				
	_	etes mellitus, chronic				
	obstructive pul	lmonary disease,				
	hypertension,	coronary artery				
	disease, chron	nic kidney disease,				
		pesity, schizoaffective				
	-	porderline personality				
	disorder.	-				
	A "Notice of A	ction Supplemental				
	Information for	Providers" form from				
	the State Medi	icaid Agency, dated				
	8/02/12 and no	oted to be a Plan of				

State Form Event ID: OWZU11 Facility ID: 005729 If continuation sheet Page 5 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		f 1	E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		LETED
			B. WING			1/2012
NAME OF I	PROVIDER OR SUPPLIE			ADDRESS, CITY, STATE, ZIP CO	DE	
CDOMAN	DOINTE OF INDIAS	NADOLIS		16TH ST		
	POINTE OF INDIAI			APOLIS, IN 46219		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	COMPLETION DATE
IAU		eriod of 10/01/12	IAU			DATE
	· ·	3, indicated "Clt has				
		sion making d/t (due to)				
	effect of Psych	• ,				
	disorders"	. (60) 01110110/				
	Medication Ad	ministration records for				
		12 indicated Resident J				
	was to check h	ner blood sugar twice a				
		to administer 45 units of				
	Levemir insulir	n each morning.				
		dent J's record, headed				
	,	New SS (sliding scale)				
		," dated 8/23/12,				
		dent J was to receive				
		Novolog insulin on a				
	_	ased on blood sugar				
	tests as follows	S:				
	 "150-174= 4 ui	nite				
	130-174- 4 ui	iiio				
	 175-199= 5 un	nits				
		·····				
	200-224= 7 un	nits				
	225-249= 8 un	nits				
	250-274= 10 u	ınits				
	0== 0==	**				
	275-299= 11 u	inits				
	200 204- 40	unito				1
	300-324= 13 u	ii iitS				1
	325-349= 14 u	ınits				
	JZJ-J48- 14 U	iiiilo	1			1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
			B. WING			12/31/	2012
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		7365 E	16TH ST		
CROWN	POINTE OF INDIAN	NAPOLIS			APOLIS, IN 46219		
(X4) ID	STIMMARYS	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
				_			
	350-374= 15 u	nits					
	000 07 1 10 0	····c					
	375-399= 17 u	nits					
	070 000 17 4	Tites					
	Notify MD if BS	6 (blood sugar) over					
	400."	o (blood sugar) over					
	-1 00.						
	During an inter	view on 12/31/12 at					
		Resident Services					
		ved the above noted					
		ated "This is this first					
	time I have see	en tnis."					
	A "Call Dagum	antation!! forms dated					
		entation" form, dated					
		Resident J's treating					
		noted to be faxed to					
		hat date, indicated					
	"WWBSSI (w	veight based sliding					
	scale insulin) is	s not going to work to					
	correct (Reside	ent J's) sugars because					
	she is highly no	on-compliant with her					
	dietdoes nur	sing staff at (name of					
	facility) know h	•					
		count?(Resident J)					
		ountlow blood sugars					
		•					
	will kill her quid						
		ng staff cannot carb					
		no point to put her on					
	_	nsulin, they will be					
		gars all day because					
	she can't eat c	orrectly"					
		d 10/02/12 indicated					
	Resident J had	d a glycohemaglobin					

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/31/2012
	PROVIDER OR SUPPLIER POINTE OF INDIANAPOLIS	7365 E	ADDRESS, CITY, STATE, ZIP CODE 16TH ST IAPOLIS, IN 46219	•
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	A1C (blood sugar) value of 9.7, noted as "High", with 3.0 to 7.0 as a reference range, and greater than 7.4 to be "Poor Control."			
	Records indicated Resident J was admitted to an acute care hospital from 10/16/12 through 10/19/12. A hospital History and Physical dated 10/16/12 indicated "Assessment/PlanDiabetes: Will place on regular insulin sliding scale"			
	Hospital records indicated Resident J was placed on the same sliding scale noted above, as follows:			
	"150-174= 4 units			
	175-199= 5 units			
	200-224= 7 units			
	225-249= 8 units			
	250-274= 10 units			
	275-299= 11 units			
	300-324= 13 units			
	325-349= 14 units			
	350-374= 15 units			

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			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		12/31/2012
NAME OF F	PROVIDER OR SUPPLIEI			ADDRESS, CITY, STATE, ZIP CODE	
				16TH ST	
CROWN	POINTE OF INDIA	NAPOLIS	INDIAN	IAPOLIS, IN 46219	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	375-399= 17 u	ınits			
	BG (blood gas Physician.") over 400 Call			
	received suppl	ds indicated Resident J lemental insulin on 10 ing her 4 day hospital s:			
	10/16/12 8:46	a.m.: 10 units			
	10/16/12 9:21	p.m.: 8 units			
	10/17/12 8:52	a.m.: 13 units			
	10/17/12 1:07	p.m.: 8 units			
	10/17/12 9:57	a.m.: 11 units			
	10/18/12 9:20	a.m.: 14 units			
	10/18/12 1:57	p.m.: 8 units			
	10/18/12 5:25	p.m.: 1 units			
	10/19/12 9:09	a.m.: 11 units			
	10/19/12 2:06	p.m.: 7 units			
	on 12/31/12 at Resident Servi	rview with Resident J 10:45 a.m., with the ices Director present, icated she did not get			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
			B. WING		12/31/2012
	PROVIDER OR SUPPLIEI		7365 E	ADDRESS, CITY, STATE, ZIP COI 16TH ST APOLIS, IN 46219	DE
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL ILSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE COMPLETION
	her blood sugar had in her "recovered sugars ranging high value "in the 450, that this in 250, and that is her blood sugar insulin. She industries were his tell facility staff. During an interpretation of the services of the p.m., she indicated additional doctor intervention. J's blood sugar administration as ordered, an aware Resider insulin coverage medication additional doctor intervention. An undated fact "Medication additional doctor in the Resident on 12/28/12 at "Policy: Resider receive medical conditions self-administer self-administer in the physician medical conditions and the physician medical conditions are physician medical conditions and the physician medical conditions and the physician medical conditions are physician medical conditions and the physician medical conditions are physician medical conditions and the physician medical conditions are physician medical conditions and the physician medical conditions are physician medical conditions and the physician physician medical conditions are physician p	ers from staff to test ar or take her insulin, sent memory" blood of from 200 to 500, a she last 2 weeks" of morning's value was she did not always test ar or administer her dicated when her blood igh, she did not always for each of the facility at 3:45 sated she had no sumentation of any plans as to ensure Resident ar testing and insulin were being performed dindicated she was not J had no sliding scale ge in her current ministration orders. Cility policy titled deministration," received lent Services Director 1:15 p.m., indicated: Lents of the facility shall sations as ordered by to treat specific ionsIf incapable to medications with or lers, a licensed nurse			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		12/31/2012
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	1
NAME OF P	PROVIDER OR SUPPLIER			16TH ST	
CROWNI	POINTE OF INDIAN	IAPOLIS		IAPOLIS, IN 46219	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	or qualified me	dication aide shall be			
	expected to ad	minister medications			
	as ordered by t	he physicianif the			
	resident does r	not meet the criteria for			
	independent ad	dministrations of the			
	medication(s),				
	` ′	will be executed by a			
	licensed nurse	•			
	medication aid	-			
	oaioation ala	····			
	The "Medication	n Administration"			
		d no reference to			
		ications, including			
	_	an interview with the			
	_	ces Director on			
		5 p.m., she indicated			
	•	no additional written			
		ng the administration			
		also indicated facility			
	practice recogr	•			
		es could not prepare or			
		ilin, and that there was			
	not always a lic	censed nurse in the			
	facility who cou	ıld administer insulin			
		ho were not assessed			
	as capable of a	administering their own			
	medications.	-			
	This state resid	lential tag relates to			
	Complaint IN00	_			

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